Nursing2004^a

5th Annual Writing Contest

We're looking for some good stories from practicing nurses like you. Who was your most unforgettable-or most challenging-patient or colleague? If you've never published before, here's a good place to start. Our editors will help polish winning entries before publication.



Stories should be 1,000-1,500 words long and can be submitted:

- by e-mail to pwolf@lww.com (type "Contest Entry" in the subject line)
- by regular mail to
 Nursing2004 Writing Contest, 323 Norristown Road, Suite 200, Ambler, PA 19002-2758
 (enclose three copies of your manuscript marked "Contest Entry" along with a disk marked as PC or Mac and the name and version of the program).
- In your e-mail or cover letter, include your name, degrees/licenses, home and work addresses and phone numbers; e-mail address; and a statement that we're the only publisher considering your article for publication.*
- All entries must be postmarked or e-mailed by August 1, 2004.
 Winners will be notified in late October and announced in the November issue of Nursing2004.
- For Nursing2004's author guidelines, visit http://www.nursing2004.com (click Journal Information, then Author Guidelines). If you don't have online access, call Patricia Wolf at 215-628-7702 to request a copy of the guidelines.

*Each submission must be an original true story not previously published or under consideration by another publisher.

All submissions become the property of Lippincott Williams and Wilkins, publisher of Nursing2004.

PCA by proxy: Too much of a good thing

BY JULIA MARDERS, RN, MS

A PATIENT WAS receiving patient-controlled analgesia (PCA) via infusion pump. The nurse awakened the patient to assess pain and, based on the patient's direction, pushed the PCA button to administer pain medication. The patient eventually became unresponsive and died.

What went wrong?

Someone other than the patient pushing the button on a PCA pump, even at the patient's request, is administering PCA by proxy. This well-intentioned "help" can lead to oversedation, opioid toxicity, or death.

Although PCA pumps include dose and time limits to prevent overmedication, the patient's participation is critical to maintain safety. A sleeping or overly sedated patient won't push the button, so the pain medication is unlikely to reach toxic levels. The nurse in this case overrode the patient's control of his medication by waking him and administering additional analgesia.

What precautions can you take?

- Educate yourself and your colleagues about PCA by proxy. Develop and follow guidelines for using PCA pumps.
- Place warning labels "For patient use only" on PCA buttons or equipment.
- Remind patients and visitors that the PCA is for patient use only and that visitors shouldn't push the button even if the patient asks. Educate them about PCA and tell them to notify a nurse if the patient seems overly sleepy.
- If a patient is difficult to arouse or has respiratory depression, assess his airway, breathing, and circulation; initiate basic life support as indicated and have someone notify the primary care provider.
- If a patient is harmed and you believe that improper use or malfunction of a PCA device played a role, notify the person at your facility who's responsible for reporting such problems or submit a voluntary adverse event report through MedWatch by calling 1-800-FDA-1088 or online at http://www.fda.gov/medwatch. ①

Although you need to support the adverse event–reporting policy of your health care facility, you may voluntarily report a medical device that doesn't perform as intended by calling MedWatch at 1-800-FDA-1088 (fax: 1-800-FDA-0178). The opinions and statements in this report are those of the author and may not reflect the views of the Department of Health and Human Services. Beverly Albrecht Gallauresi, RN, BS, MPH, coordinates *Device Safety*.

Julia Marders is a nurse-consultant at the Center for Devices and Radiological Health of the Food and Drug Administration in Rockville, Md.